164-5

DEPARTMENTS OF THE AIR FORCE,
THE ARMY, AND THE NAVY

AFR 164-5
AR 40-535
OPNAVINST 4630.9C
MCO P4630.9A

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AEROMEDICAL EVACUATION

WORLDWIDE AEROMEDICAL EVACUATION

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DECEMBER 1975

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DEPARTMENTS OF THE AIR FORCE,
THE ARMY, AND THE NAVY
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AFR 164-5/AR 40-535/OPNAVINST 4630.9C/MCO P4630.9A, 1 December 1975, is changed as follows:

Write-In Changes:

Page	Paragraph	Line	Action
3	2w(3)	2	Delete "his."
4	4a	5	Change "in his absence" to "when appropriate."
	4d(3)	5	Change "Each patient" to "Patients."
		7	Change "his person unless he is" to "their person unless they are."
	4e	15	Change "a patient" to patients."
		16	Change "him" to "them."
7	7e	25	Change "He must" to "This officer must alsd."
	7f(2)(a)	10	Change the fourth sentnence to "The valuables must be properly documented and processed in accordance with this regulation before the flight nurse signs the shipping document."
		18,19	Change "his or her" to "the."
8	8	8	Change "aera" to "area."
	8d	10	Change "his being moved" to "moving this class of patient."

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AFR 164–5
AR 40–535
OPNAVINST 4630.9C
MCO P4630.9A
1 December 1975

Aeromedical Evacuation

WORLDWIDE AEROMEDICAL EVACUATION

This regulation establishes operational and administrative responsibilities and procedures for worldwide aeromedical evacuation. It implements STANAG 3204, SOLOG 83, SEASTAG 3204, and IADB (Inter-American Defense Board) Resolution 46 by incorporating standardized aeromedical evacuation terminology and procedures which under terms of the above cited documents are binding commitments of the US Government. Requests for exception should be forwarded through appropriate channels of the Service concerned. This regulation will not be cited as authority for patient movement. Patients must be eligible for aeromedical transportation under the provisions of DOD Regulation 4515.13–R.

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1. DOD Policy:

a. It is the policy of the Department of Defense that in both peace and war the movement of patients of the Armed Forces will be accomplished by airlift when airlift is available and conditions are suitable for aeromedical evacuation, unless medically contraindicated.

b. Aeromedical evacuation will be performed only by units specifically assigned an aeromedical evacuation mission except where a commander and the senior medical officer determine the medical urgency is such that time involved in securing aeromedical evacuation service will likely endanger the life, limb or cause a serious complication resulting in permanent loss of function by the patient. Authority for use of local aircraft is vested in the base commander in accordance with the provisions of Department of Defense Regulation 4515.13–R, Air Transportation Eligibility.

2. Explanation of Terms:

a. Aeromedical Evacuation. The movement of patients under medical supervision to and between medical treatment facilities by air transportation.

b. Aeromedical Evacuation Control Center (AECC). The control facility established by the commander of an airlift division, air force,

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Supersedes AFR 164–1, AR 40–535, OPNAVINST 4630.9B and MCO P4630.9, 15 May 1964. (For summary of revised, deleted, or added material, see signature page.)

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or air command. It operates in conjunction with the command movement control center and coordinates overall medical requirements with airlift capability. It also assigns medical missions to the appropriate aeromedical evacuation elements in the system and monitors patient movement activities.

c. Aeromedical Evacuation Coordinating Officer. An officer of an originating, intransit, or destination medical facility who coordinates aeromedical evacuation activities of the facility.

d. Aeromedical Evacuation Operations Officer. A Medical Service Corps officer of the airlift force or air command who is responsible for activities relating to planning and directing aeromedical evacuation operations, maintaining liaison with medical and airlift activities concerned, operating an aeromedical evacuation control center (AECC), and otherwise coordinating aircraft and patient movement.

e. Aeromedical Evacuation System. A system which provides:

(1) Control of patient movement by air transport.

(2) Specialized medical attendants and equipment for in-flight medical care.

(3) Facilities, on or in the vicinity of air strips and air bases for the limited medical care of intransit patients entering, en route via, or leaving the system.

(4) Communication with originating, en route and destination medical facilities concerning patient requirements.

f. Aeromedical Staging Facility. A medical facility which has aeromedical staging beds, located on or in the vicinity of an enplaning or deplaning air base or air strip that provides reception, administration, processing, ground transportation, feeding and limited medical care for patients entering, en route in, or leaving an aeromedical evacuation system. A Mobile Aeromedical Staging Facility (MASF) is used in tactical aeromedical evacuation. Although function is the same as any ASF, it is comprised of tentage, equipment and supplies which are highly mobile, self-sufficient, and can be set up on a bare base or other unimproved area.

g. Ambulatory Patient. A patient requiring only sitting accommodations while in transit.

h. Attendant. Any individual other than a member of the medical crew who is authorized by competent medical authority to accompany a patient when such attendance is considered essential to the medical support or the mental or physical well being of the patient. Attendants are comprised of two basic categories, as follows:

(1) Medical Attendants. These are normally Armed Forces medical personnel (although they may be medical personnel of civilian or other Government agencies) who are required to accompany a patient on orders of competent medical authority because of a mental or physical condition.

(2) Nonmedical Attendants. These are generally family members (not necessarily a requirement) who are authorized by competent medical authority when considered necessary for the health and welfare of the patient. These attendants function under the supervision of the senior flight nurse aboard the aircraft and will provide care and support of patients as directed by that individual. Escorts and guards for prisoner patients also fall within this category.

i. Destination Medical Facility. The medical facility to which the patient is being transferred.

j. Domestic Aeromedical Evacuation. That phase of aeromedical evacuation which provides airlift for patients between points within the Continental United States (CONUS), and from near offshore installations.

k. Emergency Aeromedical Evacuation. The airlift of patients who must be moved immediately and who must normally be given an urgent precedence for air movement to save life or limb or to prevent complications of a serious disease.

l. Forward Aeromedical Evacuation. That phase of aeromedical evacuation which provides airlift for patients between points within the battlefield, from the battlefield to the initial point of treatment, and to subsequent points of treatment within the combat zone.

m. Intertheater Aeromedical Evacuation. That phase of aeromedical evacuation which provides airlift for patients from overseas areas or from theaters of active operations to the CONUS.

n. Intratheater Aeromedical Evacuation. That phase of aeromedical evacuation which provides airlift for patients between points of treatment outside the combat zone, within a theater of operations.

o. Litter Patient. A patient requiring litter (stretcher) accommodation while in transit.

p. Military Department. Either the Army, the Navy, the Air Force, or the Marine Corps.

q. Originating Medical Facility. A medical facility that initially transfers a patient to another medical facility.

r. Recovered Patient. An individual discharged from treatment by competent medical authority, who is physically able to travel unattended.

s. Remain Overnight (RON). Remaining overnight in a facility awaiting onward transportation to a destination hospital.

t. Strategic Aeromedical Evacuation. See Intertheater Aeromedical Evacuation.

u. Stretcher Patient. See Litter Patient.

v. Tactical Aeromedical Evacuation. That phase of aeromedical evacuation which provides airlift for patients between points of treatment within and from the combat zone to points outside the combat zone.

w. US Armed Forces Patient. Any of the following is considered to be a US Armed Forces patient when classified as a patient by competent medical authority (NOTE: As used in this regulation, the term patient includes both inpatients and outpatients):

(1) An active duty or eligible retired member of a military department.

(2) A dependent of a member of a military department on active duty or of a member deceased while on active duty or a dependent of a retired or deceased retired member of a military department who is authorized medical care under the provisions of AFR 168-9/AR 40-121/SECNAVINST 6320.8D/PHS GENCCIR NO 6/CG COMDTINST 6320.2B/ESSA CO-4.

(3) A US citizen civilian employee of the DOD and his lawful dependents when stationed outside the CONUS.

x. Walking Patient. See ambulatory patient.

3. Responsibilities and Procedures for Aeromedical Evacuation:

a. The Military Airlift Command (MAC) is responsible for all domestic aeromedical evacuation for the United States Armed Forces, for intertheater aeromedical evacuation, and intratheater aeromedical evacuation except as indicated in b and c below.

b. The Army component commander is responsible for providing aeromedical evacuation by organic Army aircraft within Army combat zones.

c. The Navy overseas component commander is responsible for providing aeromedical evacuation over routes solely of interest to the Navy, where the facilities of the Air Force cannot provide this service.

d. The MAC commander is responsible for providing and operating intratheater and tactical aeromedical evacuation systems for the US Armed Forces, except as noted in b and c above. These systems must:

(1) Provide, where applicable, the aeromedical evacuation function and capabilities stated in paragraph 9.

(2) Provide Mobile Aeromedical Staging Facilities (MASFs) as required on or in the vicinity of air strips and air bases for entering patients originating in the airborne objective areas and combat zone who are medically regulated to medical facilities located in the communication zone.

(3) Provide aeromedical evacuation in oversea combat areas, including airlift for patient from airborne objective areas, airlift for patients from the point of initial treatment or subsequent hospitalization within the combat zone to points outside the combat zone, and airlift for patients between points within the communications zone.

(4) Provide airlift of patients in an oversea active combat area, or other oversea areas, from points within the area to designated intransit patient facilities on MAC routes.

e. The Air Force overseas component commander is responsible for providing Aeromedical Staging Facilities (ASFs) on or in the vicinity of air strips and air bases for the limited medical care of intransit patients entering or enroute via the aeromedical evacuation system. The location of ASFs will be determined by the Air Force overseas component commander in coordination with MAC. ASFs will normally be located at an air strip or air base in the communication zone for the intransit patients entering or en route to medical facilities within the overseas theater or CONUS.

4. Selection of Patients:

a. Fitness for Air Travel. Patients selected for transportation by air must be cleared for the proposed flight by the medical officer in charge of the originating medical or intransit aeromedical staging facility, or, in his absence, by other competent medical authority. The only exception to this requirement is in forward aeromedical evacuation. (See b below.) The medical officer must balance fitness considerations with the availability of suitable in-flight medical attention, the urgency of treatment in a reception area, and the proposed altitude and flight time of the aircraft.

b. Forward Aeromedical Evacuation. The paramount need in this case is to transport the patient to the initial point of treatment as quickly as possible. Helicopters and short or vertical takeoff and landing aircraft may be used for the airlift, and under these circumstances, the only available medical personnel will often be medical technicians.

c. Intratheater and Intertheater Aeromedical Evacuation. In these types of evacuation, the benefit to the patient of transfer to an area where full medical facilities are available must be balanced against the ability of the patient to withstand the anticipated environmental conditions of the flight. When aeromedical evacuation is accomplished with pressurized aircraft, appropriately configured, equipped and carrying a trained inflight team, the patient is subjected to minor mechanical disturbance, low humidity, and a slight degree of lack of oxygen which can be countered with oxygen therapy. In time of contingency, however, conditions often may be less favorable for the intratheater or tactical aeromedical evacuation. The effects on the prospective patient of significant changes in atmospheric pressure and cabin temperature, the turbulent movement and restricted facilities must then be taken into account, with due regard to the aircraft type and flight plan.

d. Clinical Acceptance Criteria. There are no absolute contraindications to aeromedical evacuation. Each case must be judged on its merits, weighing the advantages to the patient of air transfer against the possible harmful effects of the flight. Sometimes a calculated risk must be taken. However, as a guide, it would be wise to accept the following types of patients only when there is no other acceptable means of transport, and special precautions must be taken for their care:

(1) Patients in the infectious stage of serious communicable diseases. If any are carried, special precautions must be taken for the protection of other occupants.

(2) Patients whose general condition is so poor that they are unlikely to survive the flight.

(3) Patients whose upper and lower jaws must be immobilized. Tie elastic bands will be used. It is mandatory that an emergency release mechanism be provided which can be activated by the patient or attendant. Each patient with immobilized jaws should have scissors attached to his person unless he is a class 1A or 1B patient, or under guard.

(4) Pregnant patients who are beyond 34 weeks of pregnancy are not routinely acceptable for aeromedical evacuation, but will be moved if determined medically necessary.

(5) Patients with severe anemia or recent acute blood loss should normally have a hematocrit of not less than 30 mgm% prior to entering the aeromedical evacuation system. Hematocrit should be checked within 36 hours prior to flight.

e. Pressurization. Transportation of patients by air requires special consideration of medical conditions which may be complicated by decreased oxygen tensions or by decreased atmospheric pressure. Specific attention should be directed to conditions such as cardiac failure, respiratory embarrassment, severe anemia, and trapped gas. A thorough review of medical history for evidence of recent surgery, recent acute blood loss, organic heart disease, positive sickle cell trait, decompression sickness or any other condition which may be complicated by higher cabin altitudes is indicated and advisable. It may be medically sound to delay the aeromedical evacuation of a patient rather than subject him to the hazards of traveling in an unpressurized aircraft.

5. Classification of Patients. Patients are classified in the following manner:

a. Class 1—Neuropsychiatric Patients:

(1) Class 1A—Severe Psychiatric Litter Patients. Psychiatric patients requiring the use of restraining apparatus, sedation, and close supervision at all times.

(2) Class 1B—Psychiatric Litter Patients of Intermediate Severity. Psychiatric patients requiring tranquilizing medication or sedation, not normally requiring the use of restraining apparatus, but who react badly to air travel or who may commit acts likely to endanger themselves or the safety of the aircraft. Restraining apparatus should be available for use.

(3) Class 1C—Psychiatric Walking Patients of Moderate Severity. Psychiatric patients who are cooperative and who have proved reliable under observation.

b. Class 2—Litter Patients (Other Than Psychiatric):

(1) Class 2A—Immobile Litter Patients. Patients unable to move about of their own volition under any circumstances.

(2) Class 2B—Mobile Litter Patients. Patients able to move about on their own volition in an emergency.

c. Class 3—Walking Patients (Other Than Psychiatric). Walking patients, other than psychiatric, who require medical treatment, care, assistance, or observation en route.

d. Class 4—Troop Class. Walking patients, other than psychiatric, who require no medical treatment during flight, are physically and emotionally able to travel unattended, and do not require observation or custodial care (Army military patients who do not require hospitalization or active medical supervision will be returned to the CONUS through regular administrative channels by the most expeditious means as outlined in AR 40–3, paragraph 39c).

6. Manifests and Records of Patients:

a. Manifests. Prepare patient manifests in accordance with AFR 164–3/AR 40–40/BUMEDINST 4650.2A, Documentation Accompanying Patients Aboard Military Common Carriers.

b. Medical Records. All medical records to include clinical records, outpatient treatment record, and health record, U.S. Field Medical Card, X-Rays, and any other document relating to the final destination. Place all records in an envelope, and mark the outside with the patient's name, rank or status, social security number, nationality (if not a US citizen), organization, date of departure and destination. Prepare histopathological sections accompanying aeromedical evacuation patients as prescribed in TM 8–340/NAVMED P–5083/AFM 160–28/VA Pamphlet 10–72. The flight nurse will accept only records for those patients who are present for the flight. At RON stations, all records must accompany patients to the aeromedical staging facility.

7. Responsibilities of Originating Medical Facilities:

a. Briefing of Patients. Patients and nonmedical attendants must be thoroughly briefed at originating medical facilities by an individual familiar with the aeromedical evacuation system prior to scheduled departure. Patients should also be provided a copy of the appropriate aeromedical evacuation brochure. These brochures are available from area AECCs upon request. The briefing may be verbal or written and should include:

(1) The manner in which the aeromedical evacuation system operates.

(2) The necessity for RON and regrouping of patients.

(3) Specific routing when known; otherwise, approximate routing.

(4) Estimated time en route.

(5) Baggage limitation.

(6) The need for personal funds, appropriate dress, US Department of Agriculture and Customs inspections.

(7) The availability of in-flight insurance.

(8) The destination hospital, and how it was selected.

(9) The facilities available and rules governing stay of patients and their families at aeromedical staging facilities.

(10) The requirement for attendants to pay for meals aboard the aircraft.

(11) Any other information that will be helpful to the patient.

b. Patient Support Activities. The originating medical facility must provide patient support activities with the following minimum support:

(1) Transportation for patients and recovered patients to and from the aircraft.

(2) Personnel to accompany patients, and assists in enplaning and deplaning patients.

(3) Supplies and equipment required for patients in flight, unless provided by the aeromedical evacuation unit.

(4) Inflight meals, including prescribed modified diet items, unless otherwise advised by the AECC. Precooked frozen meals are usually available for regular diets and cooked therapeutic inflight meals (CTIM) for therapeutic diets at certain originating or en route locations.

(5) A 3-day supply of drugs for patients traveling in the CONUS and within overseas theaters, except within a combat zone. In forward combat areas, the originating medical facility should provide only unique or unusual

medications. A minimum 5-day supply of drugs should be provided for patients traveling from overseas areas to the CONUS unless terminating point is at CONUS port of entry. In such cases a 3 day supply is adequate. The medication label should contain the generic name and dosage of the drug, its strength, and the name of the patient. Medications must be delivered to the flight nurse when the patient is placed aboard the aircraft. En route aeromedical staging facilities will provide supplemental medications for the anticipated duration of the flight.

(6) Arranging for guards to accompany prisoner patients to their destination.

(7) Providing a supply of formula and specialized food for infants, in an amount sufficient to last until the patient reaches the next permanent medical installation where these items can be replenished. If the formula is perishable, ingredients and directions for preparation should be included.

(8) Coordinating with the sponsoring agency (or company, in the case of civilian patients) passport and visa requirements for entry into the country in which destination hospital is located. Originating medical facility will insure that all passport and visa requirements have been met prior to requesting aeromedical evacuation and that these documents accompany the patient at time of entry into the aeromedical evacuation system.

(10) Make collections for in-flight meals from patients and attendants not eligible for subsistence without charge as prescribed in paragraph 10, below. Receipts for these collections will be provided each individual to indicate proof of payment.

c. Preparation of Patients:

(1) Patients will be classified in accordance with the categories shown in paragraph 5.

(2) Class 1A and 1B psychiatric patients must be tranquilized or sedated, placed on a litter and properly restrained (when applicable) prior to arrival at the aircraft. Psychiatric litter patients must not have items in their possession which could be used to harm themselves or others, such as matches, cigarette lighters, necklaces, neck chains, or sharp instruments. A physician may give written permission for such patients to wear spectacles and rings, and other articles considered necessary for the health and welfare of the patient. One set of restraints should be provided for each Class 1B patient.

(3) All litter patients will be clothed in hospital pajamas and delivered to the aircraft on folding canvas litters secured with two litter straps. The originating medical facility will provide the property necessary for the comfort and safety of the patient with due consideration for climatic conditions. Normally, this property will consist of 2 sheets, 1 pillow, 1 pillowcase, 2 blankets, 1 litter mattress, 1 litter, 2 litter straps or a litter harness, and pajamas, slippers and robe. Whenever equipment involving immobilization of the patient is required, the originating medical facility normally will furnish the item to prevent additional handling of patients where professionally inadvisable. Formal accountability is not required on property which accompanies a patient except for special items of equipment as specified in AR 40-538/AFR 167-5/BUMEDINST 6700.2A.

(4) Walking patients must be clothed in appropriate service uniform, except in an emergency, during field maneuvers or field exercises, or because of other unusual circumstances. Originating medical facilities must insure that walking patients have appropriate clothing for climatic conditions at intermediate stops and at destination. Walking patients with crutches or long leg casts, or whose condition does not permit the use of airline seats, are transported as litter patients and will be classified as such. Crutches and canes must accompany patients who require such items.

(5) All inpatients must wear identification bands when traveling aboard aeromedical evacuation aircraft.

(6) All patients being returned from foreign countries must meet immunization requirements for admittance to the United States, its commonwealths, territories, or possessions according to paragraph 13, AR 40-562/AFR 161-13/BUMEDINST 6230.1G. The provisions of this paragraph also apply to patients being transfererd from the United States, its commonwealths, territories, or possessions to foreign countries.

(7) Medical facility commanders are responsible for assuring that patients, classified as urgent, as well as very seriuosly ill patients, are delivered to the aircraft accompanied by a physician or nurse to brief the flight nurse on the condition of the patient and care required in flight. The necessity for a physician or special medical attendant to accompany the patient on the flight should be considered also. Once assigned to accompany a patient, the physician or special medical attendant must remain with the patient until arrival at the destination hospital.

(8) The Collins' portable traction device

will be used during the movement of patients requiring traction. This device will be provided by the originating medical facility. (NOTE: Patients requiring traction will not be transported aboard aircraft with swinging, loose weights.)

d. Family Member Accompanying a Patient. Normally, one adult member of the immediate family of a US Armed Forces patient may be authorized to accompany a patient as a nonmedical attendant when the patient's physician determines that such attendance is essential to the patient's health or welfare. Unusual circumstances may exist which require a nonmedical attendant when a member of the immediate family is not available. In this situation, the attending physician may designate a nonfamily member as nonmedical attendant. (NOTE: The Joint Travel Regulations do not authorize payment for travel or other expenses incurred by family members accompanying active duty patients as nonmedical attendants. Refer to the Joint Travel Regulations and DOD Regulation 4515.13-R for travel authorizations.)

e. Baggage. Each patient's baggage must be tagged with a DD Form 600, Patient's Baggage Tag, and delivered to the traffic representative or other designated person, along with or prior to delivery of the patient. Standard baggage allowance is 66 pounds per patient. Under extenuating circumstances or hardship situations that would prove detrimental to the patient's welfare, the medical facility commander may authorize up to 100 pounds of baggage for an Armed Forces patient. When so authorized, this must be shown in the patient's orders. Small boxes and parcels should be packed in the main luggage and not transported as hand baggage. A small handbag for toilet articles, personal items, fresh shirts, socks, etc., should accompany the patient for his use at en route and RON stops. Excess baggage must be shipped as unaccompanied baggage in accordance with applicable service directives. The officer responsible for delivery of patient's baggage to the traffic representative must take necessary steps to prevent mishandling, misplacement, or loss of baggage between the medical facilities and the aircraft. He must personally assure that patient's baggage transported corresponds with the DD Form 601. NOTE: Baggage of patients originating in hostile fire areas will be inspected by the Aeromedical Evacuation Coordinating Officer, and all hazardous material (grenades, cartridges, etc.) removed prior to delivery to the carrier.

f. Valuables. Valuables are construed to mean negotiable instruments (cash, checks, military payment orders, bonds, etc.) and jewelry having an intrinsic value requiring protection. When authorized by the medical facility commander, personal items such as wallets, keys, passes, etc. may also be classified as valuables.

(1) Valuables belonging to unconscious or otherwise incompetent patients who originate from military or other Government hospitals must be transmitted to the patient's facility must prepare a list of contents and enclose a copy with each package of valuables.

(2) Shipment through aeromedical evacuation channels will be resorted to only under unusual circumstances. In such instances, valuables are processed and handled as prescribed below:

(a) The originating medical facility must list valuables on an appropriate document. This document must be prepared in sufficient copies, using a format which will permit an exchange of responsibilities between the originating, RON, and destination facilities. The initial receipting for patient's valuables is the responsibility of the flight nurse accepting a patient from the originating medical facility. Before she affixes her signature to the "shipping document," she must first assure that the valuables have been properly documented and processed in accordance with this regulation. Each succeeding senior flight nurse accepting the patient for further aeromedical evacuation assumes responsibility for patient's valuables by properly receipting the "shipping document." Each responsible officer should retain his or her signed receipt for at least 8 months.

(b) Cash assets in excess of $25 must be converted to a United States Treasury Check or DD Form 114, Military Pay Order. Checks and Military Pay Orders are made payable to the patient concerned.

(c) An adequate container of minimum size must be provided for each patient's valuables. The container must be labeled, showing patient's full name, grade, service and service number, and name and location of the originating medical facility.

(d) The flight nurse is not required to accept a patient's valuables unless the patient concerned is physically present for the flight which the flight nurse is to accompany.

(3) The complete processing of valuables as prescribed above should be witnessed and attested to by a disinterested officer whenever possible.

(4) Mentally competent patients may retain possession of their valuables if they so

desire. However, transmittal of valuables by mail should be encouraged regardless of the competence of the patient.

g. Identification of Patients. The originating medical facility initiates DD Form 602, Patient's Evacuation Tag. Entries must be accomplished as prescribed in AFR 164-3/AR 40-40/BUMEDINST 4650.2A. In addition, military patients and military attendants must wear identification tags while traveling in aeromedical evacuation aircraft. Military dependents and others authorized medical care at Government expense should have appropriate identification cards in their possession. Class 1A, 1B, and comatose military patients must have identification tags secured to foot end of the litter. All inpatients, regardless of age, and attendants under 10 years of age must wear a "Band, Patient Identification," while in the aeromedical evacuation system.

8. Requests for Aeromedical Evacuation. Patients must be eligible for aeromedical transportation under the provisions of Department of Defense Regulation 4515.13-R, Air Transportation Eligibility. Medical facilities desiring to enter a patient into the aeromedical evacuation system must submit requests directly to the aera Aeromedical Evacuation Control Center, unless otherwise directed by the appropriate commander.

a. Information Required:

(1) Originating medical facility.

(2) Patient's name, rank, SSAN and branch of service (when applicable).

(3) Diagnosis, including significant secondary diagnoses (Diagnostic code number is not adequate).

(4) Patient classification (see paragraph 5).

(5) Destination medical facility.

(6) Movement precedence (see c below).

(7) Attendant, if any.

b. Precedence for Pickup and Movement. Patients must be evaluated and reported in accordance with paragraphs 4 and 5, and the following criteria. Over-classification must be avoided to prevent unnecessary hardship to patients on flights which might be diverted. Proper evaluation can also avoid unnecessary, costly, hazardous, or special flights. Time criteria for evacuating Priority and Routine patients may be reduced during combat situations.

(1) Urgent. For an emergency case which must be moved immediately to save life or limb, or to prevent complication of a serious illness. Psychiatric or terminal cases with a very short life expectancy are therefore not considered urgent.

(2) Priority. For patients requiring prompt medical care not available locally. Such patients must be picked up within 24 hours and delivered with the least possible delay.

(3) Routine. For patients who should be picked up within 72 hours and moved on routine or scheduled flights.

c. Reporting patients. When it has been determined at an originating medical facility that a patient may require urgent or priority evacuation, the appropriate aeromedical evacuation control center should be alerted immediately, even though the patient is not ready for transfer. This will enable the aeromedical flights for the urgent or priority requirement and to arrange possible movement of other patients on the same flight. This improves readiness to respond to the urgent or priority requirements, and makes possible more economical utilization of aircraft. Urgent cases reported within and from overseas areas normally will be evacuated to the nearest hospital having the required medical capability. When reporting routine patients to the AECC, any special considerations such as the inadvisability of RONs en route to destination, necessity to limit en route stops, special medical or dietary considerations, etc., should also be reported.

d. Very Seriously Ill Patients. Movement precedence is not necessarily influenced by a patient being classified as very seriously ill. The precedence assigned must be consistent with the urgency for delivery of the patient to his destination medical facility. A very seriously ill patient may require extensive care en route and specialized medical equipment. However, there may be no medical necessity for his being moved any faster than other routine patients.

e. Deviation from regularly scheduled flight itineraries to provide pick-up or delivery of military outpatients is not authorized. Since all active duty Armed Forces patients are entitled to travel at Government expense, medical facilities should authorize alternate modes of travel in orders issued on these patients to preclude undue delay in movement, particularly at en route stops within the aeromedical evacuation system.

9. Responsibilities of the Airlift Agencies:

a. Each airlift agency performing aeromed-

ical evacuation must establish a system which will insure effective air transportation of patients as prescribed by this regulation. Each aeromedical evacuation system includes one or more aeromedical evacuation control centers.

b. Responsibilities of aeromedical evacuation control centers include the following:

(1) Coordinating aeromedical evacuation requirements with airlift operations.

(2) Receiving, consolidating, and processing requests for patient movement, and where appropriate, transmitting these requests to other aeromedical evacuation operating elements within the system.

(3) Monitoring intransit patient handling, including the administrative processing of patients at RON stops.

(4) Monitoring appropriate records and submitting reports relating to aeromedical evacuation activities.

(5) Coordinating the timely and orderly movement of patients and establishing necessary records to make certain that patients move consistent with their date of travel readiness and operating schedules.

(6) Consolidating patient movement requests and furnishing necessary assistance to using agencies, including aeromedical evacuation liaison functions.

(7) Preparing reports to reflect patient movement and backlog for the aeromedical evacuation control center.

(8) Providing aeromedical evacuation operations officers for specific geographical areas.

(9) Advising the destination hospital when a patient is removed from the aeromedical evacuation system because of death, medical deterioration, etc.

(10) Ordering a quantity of in-flight meals, by type (breakfast, dinner or supper), and beverages for flights departing or transiting their stations.

(11) Coordinating the arrival of the aeromedical evacuation aircraft with that of the civilian ambulance agency.

c. Responsibilities of aeromedical evacuation operations officer include:

(1) Making frequent liaison visits to all medical facilities within their assigned areas for the purpose of coordinating matters pertaining to the movement of patients from the facilities by aircraft.

(2) Providing information to medical facilities regarding schedules, itineraries, RON's, flight insurance, conduct and dress aboard aircraft, and other pertinent data to assist the aeromedical evacuation coordinating officer in presenting briefings to patients scheduled for aeromedical evacuation.

(3) Participating in frequent and regular aeromedical flights to observe in-flight patient care procedures and patient ground handling procedures at onload and offload station; and developing or improving aeromedical evacuation procedures and equipment.

d. The aeromedical evacuation agency provides appropriate medical crews to insure adequate in-flight medical care. Originating medical facilities are not required to provide attendants, except in special cases or when requested by the airlift agency. Originating activities will honor requests by the airlift agency for additional medical attendants. When medical attendants are provided at the request of the airlift agency, necessary funding for per diem and travel is the responsibility of that agency. Attendants provided under any other circumstances are funded by the originating medical facility or other responsible agency. (NOTE: When a flight surgeon advisor or flight surgeon attached for flying is included as part of the medical crew aboard aeromedical evacuation aircraft, he is responsible for supervising the professional aspects of patient care, both in flight and at en route stops.)

e. Immediately prior to or upon departure of an aeromedical evacuation aircraft, the aeromedical evacuation control center must notify all intransit and destination medical facilities concerned, indicating the estimated time of arrival (ETA) and patient load data. This information must be transmitted by message, telephone, or radio to insure timely receipt at the medical facilities concerned. Aeromedical evacuation flight personnel are authorized to place collect toll telephone calls from en route stations when other means of Government communications are not available or adequate. Commanders of Army, Navy, and Air Force installations must accept collect telephone calls or messages from flight personnel accompanying patients.

f. The senior medical attendant will insure that the aircraft commander or his designated representative is thoroughly briefed prior to departure on each leg of an aeromedical evacuation mission. This briefing may be written or verbal and should include, as a minimum:

(1) Identification of seriously ill and very seriously ill patients;

(2) Psychiatric patients who are likely to cause problems during flight;

(3) Cardiac/respiratory patients who require modulation of cabin pressure changes; and,

(4) Any additional information that would assist the aircrew in conducting a safe and comfortable flight.

g. The airlift agency, insofar as possible, provides aeromedical evacuation services within the criteria set forth below:

(1) Interatheater and Intertheater Operations:

(a) MAC is responsible for publishing operational and administrative directives to implement this regulation for Interatheater and Intertheater operations.

(b) Frequency and routing of flights are determined on the basis of patient requirements established by theater commanders in coordination with MAC. Maximum cabin utilization is a desirable but secondary consideration to flight frequency and medical requirements.

(c) Allocation of space and priority of missions for aeromedical evacuation will be in accordance with the criteria established in AFR 76-38/AR 59-8/OPNAVINST 4630.18B/MCO 4630.6A.

(d) Aeromedical evacuation flights must depart within three hours of scheduled departure time, subject only to weather or other uncontrollable factors. When maintenance or other delays in excess of 3 hours are anticipated, any suitable aircraft at the station with a lower priority mission may be considered for diversion to support the aeromedical evacuation mission.

(e) To preclude unnecessary patient holding on the flight line, aircraft departure times are not established on the basis of an Estimated Time In Commission (ETIC) when maintenance is required. Departure times will be scheduled only on the basis of Firm Time In Commission (FTIC).

(2) Domestic Operations:

(a) MAC will publish operational and administrative directives to implement this regulation for domestic operations.

(b) Patients arriving from overseas should be moved from the aerial ports within 36 hours after arrival.

(c) Patients should be delivered to destination within 72 hours after pickup from aerial ports or from the originating CONUS medical facility.

(d) Patient RON stops should be limited to one if possible and not exceed two except under unusual circumstances.

(e) Patients should normally not be held in RON status for more than one night. A 48-hour RON is considered maximum except when unusual operating difficulties are encountered.

(f) En route time between RON stops for rest and recuperation normally should not exceed 12 hours.

10. In-flight Meals. Under Public Law 91-418, patients who are employees of the Government of the United States or the Government of the District of Columbia and their dependents are authorized subsistence without charge while in the aeromedical evacuation system or while in aeromedical staging facilities awaiting transportation. This includes active duty and retired members of the uniformed services, their dependents and dependents of persons who at the time of their death were active duty or retired members of the uniformed services. Other categories of patients in the aeromedical evacuation system and noncrew attendants must pay for subsistence as prescribed by appropriate directives. Originating hospitals must inform these patients and attendants that it is essential that they have sufficient funds available to defray the cost of Government-furnished meals. Originating hospitals will make collections for in-flight meals from patients and attendants not eligible for subsistence without charge. A receipt for payment will be provided, and must be produced on the aircraft as proof of payment.

11. Care of Patients That Remain Overnight (RON) Medical Facilities:

a. Responsibilities. Commanders of medical installations at locations where remain overnight facilities exist assume control of patients and their medical records upon arrival. Commanders must accept full professional responsibility for the management and treatment of patients until they depart from the facility. They must evaluate the condition of patients to determine their suitability for further airlift. Functions of medical units at RON stations include but are not limited to furnishing personnel to enplane and deplane patients; transporting patients to and from aircraft; temporary admission and assignment of patients to wards; preparing records; sending necessary communications; maintaining equipment and supplies required for patient care in flight; replacing and exchanging equipment and supplies with the airlift agency; and providing housing, meals, and transportation, if required, for aeromedical and flight crew members.

b. Patient Care. Commanders of all medical facilities will insure that the following is accomplished for all patients who RON in their facility while traveling in the aeromedical evacuation system.

(1) Each patient will be seen at least daily by a physician and will be professionally evaluated to determine:

(a) Suitability to continue travel in the aeromedical evacuation system.

(b) Treatment needs and requirements.

(c) Adequacy of previously outlined treatment plan to destination.

(d) Administration of any indicated treatment, either in a transient patient status or by transfer to the fixed medical treatment facility.

(2) Delays and changes in evacuation plans will be explained to patients promptly.

(3) Each patient will be made aware, within the limits of his disease or injury state, of the fact that he has been seen by a physician.

c. Records of Medication and Treatment. Medication and treatment administered at RON facilities are recorded on DD Form 602. Care must be exercised to insure that the time, place, and date of administering medications are recorded properly, as well as any pertinent remarks as to patient's condition or complications. This record is stapled to the SF 502 Clinical Record–Narrative Summary.

d. Patients' Valuables. RON facilities must provide measures for safekeeping patients' valuables en route. Such facilities process valuables for patients reclassified while under their jurisdiction. (For example, from Class 1C to Class 1A.)

e. In-Flight Meals. RON facilities will make collections for in-flight meals from transient patients and attendants not eligible for subsistence without charge, as prescribed in paragraph 10.

f. Preparation of Patients for Further Air Travel. In preparing patients for further air travel, the senior medical officer of the RON facility must assume all responsibilities listed in paragraph 7, assuring that every patient receives the best possible preparation, handling, and medical care.

g. Recovered Patients. RON facilities will provide transportation, meals and housing support for recovered patients.

12. Personnel, Equipment, and Facilities at Air Force Bases. Air Force medical facility commanders who provide regular RON services must give due consideration to the availability of personnel, equipment, and facilities required to accomplish their medical responsibilities for the aeromedical evacuation mission. Funds and expenses necessitated by the receiving, handling, and processing of aeromedical evacuees should be properly identified and justified as a separate entity under appropriate budget estimates.

13. Responsibilities of Destination Medical Facilities. Upon receiving the estimated time of arrival of an aeromedical evacuation flight, the aeromedical evacuation coordinating officer is responsible for effecting liaison with the appropriate air terminal facility to determine exact ETA and patient load. He must provide personnel to assist with the offloading of patients from the aircraft and arrange transportation for patients and their baggage to the receiving medical facility. A representative of the receiving facility who is authorized to receipt for patient's records, baggage, valuables, and accompanying special equipment, must meet each aircraft. The aeromedical evacuation coordinating officer must arrange for housing and meals, if required, for medical crew and flight crew personnel. The commander of the installation upon which the destination hospital is located provides necessary assistance for enplaning and deplaning litter patients at non-USAF bases or civilian airports. A physician or other competent and knowledgeable medical attendant will meet all incoming aircraft with urgent or very seriously ill patients aboard for briefing by the flight nurse, unless the patient is accompanied by a physician or special medical attendant.

14. Inquiries Concerning Loss of Baggage and Valuables. When a loss of patient's baggage or valuables occurs (excluding valuables sent by registered mail), and the exact origin of such loss cannot be determined, inquiries should be initially directed to the headquarters of the appropriate airlift agency. Inquiries should include sufficient information to permit appropriate tracer action by the airlift agency concerned.

15. Minimum Requirements for Airlift Aircraft. Except in emergencies, field exercises, or maneuvers, facilities aboard fixed-wing aircraft must meet the following minimum requirements prior to utilization of the aircraft for aeromedical evacuation in peacetime:

a. Sufficient aircraft insulation to reduce noise and increase warmth.

b. Adequate heating facilities.

c. Flexible litter and seating arrangement to permit placement of patients according to their conditions.

d. Comfortable seating. Bucket seats are not considered adequate for walking patients.

e. Adequate space for in-flight treatment of litter patients. The vertical distance between each loaded litter must not be less than 18 inches.

f. Galley facilities for storage and preparation of in-flight meals for patients.

g. Suitable hand-washing and latrine facilities for patients.

h. Pressurization capability to maintain cabin altitude at a maximum of 8,000 feet when at cruising altitude.

i. Four-engine airlift aircraft are used, when practicable, for aeromedical evacuation on long overwater routes.

j. Competent aeromedical evacuation crews must be placed aboard airlift aircraft when moving patients, unless appropriate medical authority authorizes exception in unusual circumstances.

BY ORDER OF THE SECRETARIES OF THE AIR FORCE, THE ARMY, AND THE NAVY

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SUMMARY OF REVISED, DELETED, OR ADDED MATERIAL

This revision generally updates the entire text, and includes major changes as follows: Defines the function of an aeromedical staging facility (para 2f); clarifies the definition of tactical, intratheater and intertheater aeromedical evacuation (paras 2m and n); defines medical and nonmedical attendants (para 2h); clarifies responsibilities and procedures for aeromedical evacuation (para 3); redefines clincial acceptance criteria for patients with immobilized jaws (para 4d); outlines the hazards of using unpressurized aircraft for patient movement (para 4e); redefines Class 1A, 1B, 3 and 4 patients (para 5); describes records which must accompany pati-

ents (para 6); significantly expands responsibilities of originating medical facilities (para 7); deletes travel authorizations, referring instead to appropriate transportation directives (para 8); differentiates seriously ill patients from those requiring higher movement precedence (para 8e); clarifies payment procedures for in-flight meals (para 10); outlines responsibilities of RON medical facilities (para 11); requires competent medical attendants to meet flights with urgent or very seriously ill patients aboard (para 13); deletes special administrative responsibilities and procedures in overseas areas of operation; deletes the listing of aeromedical evacuation control centers.

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